



State of New Mexico
Medical Assistance Program Manual
Supplement



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TO: ALL PROVIDERS PARTICIPATING IN THE NEW MEXICO MEDICAID PROGRAM

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SUBJECTS: **REPORTING REFERRING/PRESCRIBING/ORDERING PROVIDERS, REPORTING OF PROVIDER PREVENTABLE CONDITIONS, AND PROVIDER TERMINATIONS**

- I. REPORTING REFERRING/PRESCRIBING/ORDERING PROVIDERS**
- II. PROVIDER PREVENTABLE CONDITIONS: Hospital Acquired Conditions – Inpatient**
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I. REPORTING REFERRING/PRESCRIBING/ORDERING PROVIDERS

In compliance with the requirements of the Patient Protection and Affordable Care Act (PPACA), the New Mexico Medicaid program is reminding providers to report referring, ordering or prescribing providers on claims.

All claims submitted for the New Mexico Medicaid FFS program to Xerox (formerly ACS) company (or, for pharmacy claims, to the Xerox/ACS PDCS system) for payment for ordered, prescribed or referred items or services must include the National Provider Identifier (NPI) of the ordering, prescribing or referring physician or other practitioner.

Providers of services that are ordered or prescribed (such as a laboratory or radiology facility, a pharmacy or medical supply company) will always need the NPI of an ordering or prescribing practitioner in order to submit their own claims for payment to the New Mexico Medicaid program. We strongly urge providers to share their NPIs with these other entities. When ordering, referring or prescribing services, please make your NPI available to the providers who will be providing services.

The NPI is reported in the following ways:

- CMS-1500 : Report the NPI of the referring /ordering / prescribing provider in Field Locator 17b
- UB-04 : Report the NPI of the referring /ordering provider in Field Locator 78
- Pharmacy: Mandatory for NCPDP (pharmacy transactions) – report the NPI of the prescribing provider in segment 411-DB
- Electronic: When billing electronically, corresponding fields on the 837 electronic transaction must contain the information. The following loop, segment and element places may be used in order to report the referring or ordering provider's NPI and name:

Referring Provider Last Name – 2310A, NM1/DN, 03
 Referring Provider First Name – 2310A, NM1/DN, 04
 Referring Provider's NPI – 2310A, NM1/DN, 09

Ordering Provider's Last Name – 2420E, NM1/DK, 03
 Ordering Provider's First Name – 2420E, NM1/DK, 04
 Ordering Provider's NPI – 2420E, NM1/DK, 09

For claims with dates of service July 1, 2012 or later, when there is not a referring, ordering or prescribing NPI on claims submitted by the following types of providers, the claim will be denied:

- 336 - Orthotist
- 337 - Prosthetist
- 338 - Prosthetist & Orthotist
- 351 - Lab, Clinical Free Standing
- 352 - Radiology Facility
- 353 - Lab, Clinical With Radiology
- 354 - Laboratory, Diagnostic
- 411 - Department Store
- 414 - Medical Supply Company
- 415 - IV Infusion Services
- 416 - Pharmacy
- 451 – Occupational Therapist, Licensed & Certified
- 452 – Occupational Therapist Licensed
- 453 - Physical Therapist, Licensed & Certified
- 454 - Physical Therapist, Licensed
- 455 - Rehabilitation Center, Certified
- 417 – Clinic, Rural Health Pharmacy

When a provider does not have an individual NPI, but is permitted under State law to order, prescribe or refer services for Medicaid eligible recipients, a provider may use the NPI of the facility or hospital out of which they practice. Common examples are interns, and possibly residents, practicing at the University of New Mexico Hospital; practitioners practicing at Indian Health Services (IHS) clinics; or, practitioners working at a comprehensive outpatient rehabilitation facility (CORF). In these cases, a provider may use the NPI of the facility as the referring, ordering or prescribing

NPI. All other providers should report the referring, ordering, or prescribing NPI as applicable.

The National Plan & Provider Enumeration System (NPPES) maintains a website (<https://nppes.cms.hhs.gov/>) where the NPI Registry may be searched to find a specific provider's NPI number.

SECTIONS II AND III: PROVIDER PREVENTABLE CONDITIONS

Federal regulations released by the Centers for Medicare and Medicaid Services (CMS) on June 6, 2011 outlined the final requirements regarding *Payment Adjustment for Provider-Preventable Conditions Including Health Care-Acquired Conditions*.

These regulations implemented Section 2702 of the Affordable Care Act (ACA, P.L. 111-148 and P.L. 111-152), which requires the Secretary of Health and Human Services (HHS) to issue regulations prohibiting federal payments to states for providing medical assistance for Provider Preventable Conditions (PPCs), effective July 1, 2011. The final rule requires that state Medicaid programs implement non-payment policies for provider preventable conditions (PPCs) including health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

PROVIDER PREVENTABLE CONDITIONS : HOSPITAL ACQUIRED CONDITIONS - INPATIENT

One category of PPCs is Hospital Acquired Conditions (HACs), which apply to all inpatient settings.

Effective July 1, 2012 the New Mexico Medicaid Program is adopting the CMS present on admission (POA) / Hospital-Acquired Conditions (HAC) policy and will begin to deny claims that indicate that the diagnosis was not present on admission or that the documentation is insufficient to determine if condition was present at the time of inpatient admission. Conditions / diagnosis codes are identified by CMS as HACs when not present on hospital admission.

Hospital Acquired Conditions:

The following are conditions or events considered to be HACs:

- Foreign Object Retained After Surgery
- Air Embolism
- Blood Incompatibility
- Stage III and IV Pressure Ulcers
- Falls and Trauma; including Fractures, Dislocations, Intracranial Injuries , Crushing Injuries, Burns, Electric Shock
- Catheter-Associated Urinary Tract Infection (UTI)
- Vascular Catheter-Associated Infection

- Manifestations of Poor Glycemic Control; including: Diabetic Ketoacidosis, Nonketotic Hyperosmolar Coma, Hypoglycemic Coma, Secondary Diabetes with Ketoacidosis, Secondary Diabetes with Hyperosmolarity
 - Surgical Site Infection Following:
 - Coronary Artery Bypass Graft (CABG) - Mediastinitis
 - Bariatric Surgery; including Laparoscopic Gastric Bypass, Gastroenterostomy, Laparoscopic Gastric Restrictive Surgery
 - Orthopedic Procedures; including Spine, Neck, Shoulder, Elbow
- Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Total Knee Replacement or Hip Replacement with pediatric and obstetric exceptions

Reporting the Present on Admission Indicator

Providers must follow the official POA coding guidelines as set forth in the *UB-04 Data Specifications Manual* and in the *ICD Official Guidelines for Coding and Reporting*, or their successors. Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission. POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the *Official Guidelines for Coding and Reporting*) and the external cause of injury codes. Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider. If a condition would not be coded and reported based on Uniform Hospital Discharge Data Set definitions and current Official Guidelines, then the POA indicator would not be reported.

Providers of inpatient DRG claims will be required to use the “present on admission” indicator on claims for all primary and all secondary diagnoses. If a condition is not present on admission, meaning that it was acquired during the inpatient stay, the New Mexico Medicaid program will not pay for any services or procedures involved in the treatment of that condition.

For DRG cases, the DRG payable shall exclude the diagnoses not present on admission for any Health-Care Acquired Conditions (HCAC). Claims will be paid as though the diagnosis code is not present.

Paper Claims

On the UB-04, the POA indicator is the eighth digit of Field Locator (FL) 67, Principal Diagnosis, and the eighth digit of each of the Secondary Diagnosis fields, FL 67 A-Q. In other words, report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting.

INDICATOR	DESCRIPTION	MEDICARE PAYMENT
Y	Diagnosis was present at time of inpatient admission.	Payment made for condition , when an HAC is present

N	Diagnosis was not present at time of inpatient admission.	No payment made for condition, when an HAC is present
U	Documentation insufficient to determine if condition was present at the time of inpatient admission.	No payment made for condition, when an HAC is present
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.	Payment made for condition, when an HAC is present
1 or blank	Exempt from POA reporting. This code is the equivalent of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1. NOTE: The number “1” is no longer valid on claims submitted under the version 5010 format, effective January 1, 2011. The POA field will instead be left blank for codes exempt from POA reporting.	Exempt from POA reporting
Z	Indicates end of the data.	

Electronic Claims

Using the 837I, submit the POA indicator in segment K3 in the 2300 loop, data element K301.

EXAMPLE 1: POA indicators for an electronic claim with one principal and five secondary diagnoses coded as POAYNUW1YZ would represent the following:

- POA “POA” is always required first, followed by a single indicator for every diagnosis reported on the claim.
- Y The principal diagnosis is always the first indicator after “POA.” In this example, the principal diagnosis was present on admission.
- N The first secondary diagnosis was not present on admission, designated by “N.”
- U It was unknown if the second secondary diagnosis was present on admission, designated by “U.”
- W It is clinically undetermined if the third secondary diagnosis was present on admission, designated by “W.”
- 1 The fourth secondary diagnosis was exempt from reporting for POA, designated by “1.”
NOTE: Hospitals reporting with the 5010 format on and after January 1, 2011 will no longer report a POA indicator of “1” for POA exempt codes. The POA field will instead be left blank for codes exempt from POA reporting.
- Y The fifth secondary diagnosis was present on admission, designated by “Y.”
- Z The last secondary diagnosis indicator is followed by the letter “Z” to indicate the end of the data element.

EXAMPLE 2: POA indicator for an electronic claim with one principal diagnosis without any secondary diagnosis should be coded as POAYZ, if the diagnosis was present on admission.

- POA “POA” is always required first, followed by a single indicator for every diagnosis reported on the claim.
- Y The principal diagnosis is always the first indicator after “POA.” In this example, the principal diagnosis was present on admission.
- Z The letter “Z” is used to indicate the end of the data element.

This requirement does not apply to the following: critical access hospitals (CAHs), extended care hospitals, inpatient psychiatric hospitals, inpatient rehabilitation hospitals, or PPS-exempt inpatient rehabilitation or psychiatric units.

II. PROVIDER PREVENTABLE CONDITIONS: ALL HEALTHCARE PROVIDERS

The second category of PPCs is Other Provider Preventable Conditions (OPPCs), and applies to all Medicaid enrolled providers including physicians, inpatient and outpatient hospitals, ambulatory surgical centers, and other facilities. OPPCs are conditions occurring in any health care setting that could have reasonably been prevented through the application of evidence based guidelines. Providers are required to report on a claim if an OPPC occurs. If a provider reports any of the below diagnosis codes on a claim, the reduction in payment will be limited to the amounts directly identifiable as related to the PPC and the resulting treatment.

OPPCs are defined as the following:

CONDITION	ICD-9 CODE
Performance of wrong operation (procedure) on correct patient Wrong device implanted into correct surgical site Excludes: correct operation (procedure) performed on wrong body part (E876.7)	E876.5
Performance of operation (procedure) on patient not scheduled for surgery Performance of operation (procedure) intended for another patient Performance of operation (procedure) on wrong patient	E876.6
Performance of correct operation (procedure) on wrong side/body part Performance of correct operation (procedure) on wrong side Performance of correct operation (procedure) on wrong site	E876.7

Also, if a provider reports any one of the below modifiers on a claim, the reduction in payment would be limited to the amounts directly identifiable as related to the OPPC and the resulting treatment.

PA - SURGERY, WRONG BODY PART
PB - SURGERY, WRONG PATIENT
PC - WRONG SURGERY ON PATIENT

The New Mexico Medicaid program will continue to follow CMS guidelines and national coverage determinations (NCDs), including any future additions or changes to the current list of HAC conditions, diagnosis codes, and OPPCs.

Providers may read more about the Provider Preventable Conditions policy on the CMS website, at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Provider-Preventable-Conditions.html>

III. PROVIDER TERMINATIONS

Section 6501 of the Affordable Care Act amends section 1902(a)(39) of the Social Security Act (the Act) and requires all State Medicaid agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or any other State Medicaid plan. In final implementing regulations at 42 CFR § 455.101, CMS generally defined “termination” as occurring when a State Medicaid program, CHIP, or the Medicare program has taken action to revoke a Medicaid or CHIP provider’s or Medicare provider or supplier’s billing privileges and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. CMS also indicated in final implementing regulations at 42 CFR § 455.101, that the requirement to terminate under section 6501 of the Affordable Care Act only applies in cases where providers, suppliers or eligible professionals have been terminated or had their billing privileges revoked “for cause.”

We are providing the following information just to assure that providers are informed of federal requirements.

Examples of For Cause Terminations

The following list is not exhaustive and is intended only to give States guidance as to the type of “for cause” terminations that CMS believes to be within the spirit of the final rule.

1. Providers that are terminated by State Medicaid Agencies as a result of adverse licensure actions, e.g., providers who are reported into the National Practitioner Data Bank (NPDB).
2. Providers that are terminated by State Medicaid Agencies because they have engaged in fraudulent conduct.

3. Providers that are terminated by State Medicaid Agencies due to abuse of billing privileges, e.g., billing for services not rendered or for medically unnecessary services.
4. Providers that are terminated by State Medicaid Agencies due to misuse of their billing number.
5. Providers that are terminated by State Medicaid Agencies due to falsification of information on enrollment application or information submitted to maintain enrollment.
6. Providers that are terminated by State Medicaid Agencies due to continued billing after the suspension or revocation of the provider's medical license.
7. Providers that are terminated by State Medicaid Agencies based on a State and/or Federal exclusion.
8. Providers that are terminated by State Medicaid Agencies due to falsification of medical records which support services billed to Medicaid.

The New Mexico Medicaid program has changed provider enrollment processes and forms in order to meet federally mandated requirements. The new provider participation agreement forms may be viewed on the Medical Assistance Division's website under "Provider Enrollment & Program Policy" at <http://www.hsd.state.nm.us/mad/PEenrollmentPolicy.html> Current providers do not need to submit a new provider participation agreement at this time. The new wording will be reflected in the periodic renewals and re-verifications of information requested from the provider by ACS, a Xerox company.

If you have questions regarding the above information, you may contact the Medicaid Program Benefits Bureau at (505) 827-3171.

We appreciate your participation in the Medicaid program.